Last Name:_____First Name:_____Date of Birth: __ __/__ __/__ __ __ __

__ __/__ __/__ __ __ __
Date Assessment Reviewed

__ __/__ __/__ __ __ __
Date Assessment Completed

_____
Assessment Reviewed by
(HCP Staff Name & Title)

_____
Assessment Reviewed by

_____
Family Member

_____
Family Member

AP = Check if item will carry over to the Action Plan

✓AP	Family Strengths & Concerns	Comments
	CYSHCN/Family Concerns	
	Family Activities Together	
	Other Children or Adults with Special Health Care Needs in Household	
	Self-Advocacy Skills	
	Health Literacy	
	Community Support	
	Cultural Health Beliefs	
	Other	

Last Name:_____First Name:_____Date of Birth: __ __/__ __/__ __ __ __

AP = Check if item will carry over to the Action Plan

✓AP	Insurance Type(s)	Comments
	Medicaid	
	CHP+	
	SSI	
	Straight	
	Waiver	
	Private	
	Discount Programs	
	Self-Pay	
	Other	

✓AP	CYSHCN Medical	Comments
	Dental	
	Durable Medical Equipment/Modifications	
	Home Health Services	
	Medications	
	Nutrition	
	Vision	
	Other	

Last Name:_____First Name:_____Date of Birth: __ __/__ __/__ __ __ __

AP = Check if item will carry over to the Action Plan

✓AP	CYSHCN Developmental	Comments
	Developmental Status	
	Developmental Testing or Screenings	
	Hearing	
	Motor	
	Speech	
	Other	

✓AP	CYSHCN Emotional	Comments
	CYSHCN's Social/Emotional Status	
	CYSHCN's Relationship with Family	
	Family's Relationship with CYSHCN	
	Other	

✓AP	CYSHCN Therapies	Comments
	Behavioral	
	Mental Health Specialists	
	Occupation Therapy	
	Physical Therapy	
	Speech Language Pathology	
	Vision	
	Recreational, Massage, Developmental	
	Other	

Last Name:_____First Name:_____Date of Birth: __ __/__ __/__ __ __ __

AP = Check if item will carry over to the Action Plan

✓AP	Education	Comments
	School Name/Grade	
	Learning Style	
	504 Plan	
	Early Intervention Services (IFSP)	
	Part B (IEP)	
	Special Education	
	Transition Plan	
	Other	

✓AP	Basic Needs	Comments
	Clothing	
	Employment	
	Electricity	
	Family Planning	
	Food	
	Income	
	Housing	
	Phone	
	Other	

Last Name:_____First Name:_____Date of Birth: __ __/__ __/__ __ __ __

Select up to 5 medical conditions. Enter in the CYSHCN Data System

❑ Allergies (severe)	❑ Failure to thrive
❑ Arthritis or other joint problems	❑ Gastrointestinal problems
❑ Asthma	❑ HIV/AIDS
❑ Attention deficit disorder or attention deficit hyperactivity disorder (ADD or ADHD)	❑ Hydrocephalus/anencephaly/microcephaly
❑ Autism Spectrum Disorder (including Asperger's syndrome, pervasive development disorder)	❑ Immune system disorder
❑ Blood problems (such as anemia, sickle cell disease, hemophilia)	❑ Kidney disease
❑ Brain injury (acquired)	❑ Learning problems
❑ Brain injury (traumatic)	❑ Limb reduction anomalies
❑ Cardiac defect	❑ Mental health problems – diagnosed (such as depression, bipolar disorder, personality disorder, schizophrenia)
❑ Cardiac disease	❑ Mental health/behavioral problems - undiagnosed
❑ Cerebral palsy	❑ Metabolic disorders
❑ Chromosomal disorders & genetic syndromes (other than Down syndrome)	❑ Migraines or frequent headaches
❑ Chronic ear infections	❑ Movement disorders (such as Tourette syndrome, tics)
❑ Circulatory system problems (excluding cardiac problems)	❑ Musculoskeletal disorders
❑ Cleft lip and/or palate	❑ Neoplasms - benign
❑ Congenital anomalies	❑ Neoplasms - malignant
❑ Connective tissue disorders (such as osteogenesis imperfecta)	❑ Neurofibromatosis
❑ Cystic fibrosis	❑ Neurological disorders
❑ Degenerative neuromuscular disorders (including muscular dystrophy)	❑ Newborn Intensive Care Unit (NICU) graduate
❑ Developmental delay - cognitive	❑ Spinal injuries
❑ Developmental delay – global	❑ Prematurity
❑ Developmental delay - motor	❑ Obesity
❑ Developmental delay - speech	❑ Recurrent urinary tract infections
❑ Developmental disability	❑ Skin & subcutaneous tissue problems
❑ Diabetes	❑ Spina bifida
❑ Down Syndrome	❑ Spinal disorders
❑ Eating disorders	❑ Trouble hearing/deafness
❑ Endocrine disorder (other than diabetes)	❑ Trouble seeing/blindness
❑ Epilepsy or seizure disorder	❑ Unknown/other conditions

ICD-9 Codes (Optional) | | | |